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that and -- there is a difference between that and then what physicians are getting for that. You know, in my word, I'm using -- my word is "inflated," but clearly in the context --
Q. Well, you said --
A. -- that you're picking it out of the transcript, I'm not -- it's probably not the best choice of words.
Q. I want you to be comfortable with your testimony.
A. Sure. Sure.
Q. Let me back up then. Based on what you just said --
A. Uh-huh.
Q. -- you understand that there's a difference between AWP and what a physician pays to acquire a drug, right?
MR. COCO: Objection.
A. I would say, again, back to when we -- before the break.
Q. Just that there's a difference?
A. A reasonable difference.

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Q. Fine.
A. Because that's a difference.
Q. Okay. My first -- my question, and this, I think, is a yes-or-no question, do you understand there to be a difference? In other words, do you understand that physicians are not paying AWP to acquire drugs?
MR. COCO: Objection.
A. A reasonable difference, yes.
Q. How long have you known that physicians are not paying AWP to acquire drugs?
MR. COCO: Objection.
A. I couldn't put dates around this. Again, it were -- I don't know.
Q. Are you familiar with publicly-published documents dealing with this topic?
MR. COCO: Objection.
A. I'm -- no, not specifically, no.
Q. Let me show you a document that we'll mark as Exhibit Fox 002.
(Memo, 11/6/92 marked Exhibit Fox 002.)

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Q. Now, are you familiar, Mr. Fox, with the Department of Health and Human Services?
A. I am.
Q. And are you familiar with the OIG or the Office of the Inspector General within that department?
A. I am.
Q. You are aware that the OIG studies certain issues for The Department of Health and Human Services and puts out reports dealing with those issues?
A. I'm not -- I mean, I don't follow their work directly. So, I don't know what it is specifically they do.
Q. Okay. But you are familiar with the existence --
A. Of the OIG?
Q. Yes.
A. Oh, yes.
Q. Okay. Now, this memo is dated November 6th, 1992. Do you see that?
A. I do.

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Q. That's about the same time you were starting to work with providers, right?
A. Roughly.
Q. Now, I'd like you to turn to the second full paragraph on that first page which states, "Our results indicate that, for the physicians surveyed, the 13 chemotherapy drugs can be purchased at amounts below the established average wholesale price."
Now, just sticking with that for the moment, that's the same thing you just said, right? You understand physicians don't pay AWP to acquire drugs.
MR. COCO: Objection.
A. Well, I'm reading this -- I mean, I'm -- I'm reading this for the first time. I have not seen this document before.
Q. My question is, do you understand that sentence to have the same meaning as what you just said; that physicians do not pay AWP to acquire drugs?
MR. COCO: Objection.

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A. I don't know that it's the same.
Q. Okay. What's the difference?
MR. COCO: Objection.
A. Again, I'm reading something that's been -- that's in writing in this document, which is different than what my understanding is in conversations in general with physicians, so --
Q. Okay. That's the issue. You're saying it's different. How is it different?
MR. COCO: Objection.
A. Again, you know, I'm -- I'm just making a statement that my understanding would be that there is a difference, you know -- I don't know what the person who wrote this memo -- I have no idea --
Q. Okay. Well --
A. -- what the context of the memo is or what the rest of it is for.
Q. Well, let me ask you a question.
MR. COCO: Adeel, I know you're trying to get to your next question, but you really need to let him finish this question.

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Q. Were you finished? Were you still speaking,
A. Well, no, I was saying that --
Q. Okay.
A. -- you know, you're asking me to read a memo that I don't even know what the subject is from somebody who I don't know.
Q. That's fine.
A. That's 15 years ago.
Q. The subject is, "Physicians' Costs For Chemotherapy Drugs." You see that at the top, right?
A. I do.
Q. It's from the OIG. You know who the OIG are, right?
A. I do.
Q. Now, my question is, this survey -- this publicly-published report from 1992 says, "Our results indicate that for the physicians surveyed, the 13 chemotherapy drugs can be purchased at amounts below the average wholesale price."
Now, my question is --

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A. Uh-huh.
Q. -- isn't that the same point that you just made, that physicians can buy drugs at an amount less than average wholesale price?
MR. COCO: Objection.
A. I -- I would say -- I would say it's not necessarily the same point.
Q. Okay. What's the difference? That's what I'm trying to understand.
MR. COCO: Objection.
A. Well, the difference, first of all, is this is in writing, and I don't know -- again, I'm not -- I'm not aware of this particular document.
Q. I'm not addressing the form of it.
A. Right.
Q. I'm addressing the substance of it. What's the substantive difference between this and your understanding --
MR. COCO: Objection.
Q. -- that we just discussed?
A. Well, to me, the difference would be what my personal understanding, not based on

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anything that I'm reading and not having a document in front of me that -- that concurs with what I'm saying, versus reading something that someone wrote in a document which I've not seen.
Q. Okay.
A. There's a difference between my believing or my understanding of something versus having documented proof that something exists, if you will.
Q. That's axiomatic. My question is, aren't you and this document saying the same thing, that drugs -- chemotherapy drugs can be purchased at amounts below the average wholesale price?
MR. COCO: Objection.
A. No, I think you're drawing -- no, I don't think --
Q. Let me ask you a different question.
MR. COCO: Adeel, again, let him finish his answer completely.
Q. Go ahead. Are you done?
A. I would say -- well, I was finishing. I

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don't think it's the same, because in what I'm reading here, I mean, there's lots of things that are going into this document, which I have no idea what they are. He's talking about things, and I don't know specifically what they're referencing. I just happened to -- I just made a statement to you about what my understanding is based on my understanding of physician reimbursement.
Q. Okay.
A. So, I'm not going to -- I cannot draw -- and I will not draw -- any conclusion between the document that I didn't write and I didn't read, versus something that I understand from 15 years ago. I guess that's my point.
Q. I asked you earlier today can physicians buy drugs at amounts lower than the average wholesale price. You agreed with that, right?
MR. COCO: Objection.
Q. Regardless of this document.
MR. COCO: Objection.
A. I don't know what I said. I'd have to read the testimony.

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Q. Well, let me ask you again. To your knowledge, do physicians pay AWP to acquire drugs they administer in office, or do they pay something less than AWP?
MR. COCO: Objection.
A. Again, I would -- my answer would be that the AWP is -- is the price that we're all using as the reference point, and they -- if they're paying something different -- they may be; they may be paying something different. Have I seen evidence of that? I guess the answer would be no.
I would assume that if -- and again, I would assume it to be -- I keep going back to the word I use, which is "reasonable." If there is a difference, that it would be reasonable. And since you keep circling around my statement, I just want that part clarified that that's what I'm meaning.
Q. Okay.
A. I understand the question.
Q. Now, let's go back to your term that you

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would understand the difference to be reasonable. What do you mean by that?
MR. COCO: Objection.
A. I think we talked about it before. I don't have a numeric number in my mind. I just know it -- reasonable.
Q. Well, tell me generally, without a numeric number, what do you mean by "reasonable"? What would be reasonable, and what -- what are we talking about?
MR. COCO: Objection.
A. Our reimbursement methodology in general, we want to pay cost and be reasonable in any margin that is generated. That's typically what our methodology is. Whether it's a physician or some other group, we would expect a reasonable margin.
Q. Okay.
A. But, again -- so when you -- so, I don't have a definition of what that means. What that would mean is that since we're talking about services that our customers pay, we would expect

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that number to be reasonable. I wouldn't expect it to be unreasonable.
Q. Okay. I'm not disputing that. Okay. Let me just be clear.
A. Sure.
Q. I understand what you're saying. You expect it to be reasonable. And that's fine. I'm not trying to move you off that.
A. Sure.
Q. I'm just trying to understand what you mean by it. Okay.
A. Sure.
Q. Now, let me ask you a question: When you say -- let me see if I understood you correctly. Your understanding is that the amount you reimburse is -- approximates the cost plus a reasonable margin, right, to the physician?
MR. COCO: Objection.
A. In general, for services in general.
Q. And for drugs.
MR. COCO: Objection.
A. Well, again, I'm -- again, I gave you --

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our methodology in general is to pay and be reasonable if there is -- if there is a margin there. I -- you know, for most medical services, I don't think there is a margin there. I think there -- if anything, it's probably just a cost. I don't know specific for pharmaceuticals or for physician -- I think we're talking about the nonretail stuff here. Again, if there is a margin, then I would expect it to be reasonable.

I don't have -- I don't have fee schedules or price information in front of me where you're pointing out numbers, but again, just in general terms.

Q. Okay. Let me ask you specifically about drugs administered by physicians in office.

A. Uh-huh.

Q. Is it Blue Cross Blue Shield of Massachusetts' intention to pay cost plus a reasonable margin --

MR. COCO: Objection.

Q. -- when reimbursing a physician?

A. I think, in general, consistent with our

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policy, we should pay -- we should pay cost. And if -- and again, but see, here's the difference. When we say, "reasonable margin -- reasonable physician margin," the physician is passing on to us. I'm not making any other assumptions in that as to, you know, how they got whatever they got and what they paid for it.

So, I'm just saying that that's what I mean by "reasonable."

Q. Well, what do you mean when you say -- well, margin is referring to the difference between what the physician paid and what he's being reimbursed, right?

A. In this instance, yes.

Q. Okay. So -- okay. Now, when you say that you expect there to be a reasonable margin, are you assuming that the AWP has some fixed relationship to the acquisition price the physician is paying to acquire the drug?

MR. COCO: Objection.

A. Say that again.

Q. When you say you expect there to be a

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reasonable margin, my question is, are you expecting the AWP to bear some fixed relationship to the amount the physician paid to acquire the drug?

MR. COCO: Objection.

A. I'm assuming, again, we're -- I'm not -- I don't get into that kind of specifics. So, you know, I don't know. I guess what I'm saying is that AWP is the number, and acquisition cost is a number, and if there is a difference, then there is a reasonable difference. I guess, I mean, that's what I -- that's what I'm saying.

Q. Okay. That difference is the margin, right?

MR. COCO: Objection.

A. I don't know if that's what -- what -- I don't know if that's how anyone would define it, as a margin.

Q. Well, when you were talking about margin earlier in relation to drugs administered in office, what were you referring to?

MR. COCO: Objection.

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A. I think I'm referring specifically to what we're reimbursing versus what they're paying for that drug.

Q. Okay. So, you're talking about the difference between the reimbursement rate, which is the AWP-based rate, and the physician's acquisition cost for the drug.

A. That's right.

MR. COCO: Objection.

Q. All right. Now, is it your expectation or understanding -- I understand you think that the relationship will be reasonable -- but do you understand that there would be a fixed relationship or an identifiable consistent relationship between those two numbers?

MR. COCO: Objection.

A. I would have no way to -- I don't have an opinion on that. I wouldn't know.

Q. Is there a reasonably-predictable relationship between all physicians' acquisition cost for all drugs and AWP?

MR. COCO: Objection.

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A. Again, outside the realm of my knowledge. I wouldn't know that.
Q. Okay. So, you personally have no such expectation, is that a fair statement?
MR. COCO: Objection.
A. No, I'm saying I don't know.
Q. So, you have no expectation.
MR. COCO: Objection.
A. I don't know the answer. So whether I have or have not, I just -- I'm saying that's not a part of the business that I'm involved in, so I don't know.
Q. Let me turn you back to Exhibit Fox 002, and look at the next part of the sentence that we were reading.
A. Uh-huh.
Q. And that, "AWP is not a reliable indicator of the cost of a drug to physicians." Do you see that?
A. I see it.
Q. Okay. What do you understand that to mean?

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MR. COCO: Objection.
A. I'm reading the same thing you're reading, so I have not seen that in writing before, so I'm just reading what it says.
Q. Okay. Well, my question is, when this report uses the term as "not a reliable indicator --"
A. Uh-huh.
Q. -- what do you understand that to mean as you read it today?
MR. COCO: Objection.
A. Again, I -- I understand this is a document that you're saying is a publicly-available document. I've not read it, so I can't tell you what someone in 1992 meant when they say it. I'm reading what you're -- I'm reading the sentence the same as you, but I'm not going to impute what I think someone else meant.
I'm reading the statement, and I understand the statement as it's written.
Q. Well, that's my -- that's my question. I'm not asking you to --

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A. Sure.
Q. -- get into the mind of the author.
A. Sure.
Q. My question is, as you read this, what is your understanding as to what the author is saying? Do you understand my question?
MR. COCO: Objection.
Q. Go ahead.
A. I'm not -- I'm reading the same sentence, "AWP is not a reliable indicator of the cost of a drug to physicians." Whether I agree with that or whether I know it, again, I've not seen this in writing before. I don't have this as a basis of any of my information, so I can't -- if you're asking me to agree with a statement that someone else wrote, I can't do it.
Q. No, I'm asking you what do you understand it to mean?
A. I don't understand it to mean anything what it says. I don't know if I'm missing something.
Q. Okay. You're saying it's self-evident

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in what it means.
MR. COCO: Objection.
A. Again, I read the same thing that you're reading, and I don't draw any conclusion from it, other than what it says -- no different than any other document that's put out by The Department of Health and Human Services.
Q. Now, what do you understand -- you understand that Blue Cross Blue Shield of Massachusetts is a Plaintiff in this case, right?
A. I do.
Q. What do you understand Blue Cross Blue Shield of Massachusetts is alleging the Defendants did wrong in this case?
A. My understanding is that there is a -- not a reasonable difference between the average wholesale price and the acquisition costs that a physician pays, and, therefore, the reimbursement that we're providing to the physician is not a reasonable margin. I mean, boiling that down into my basis.
Q. Now, when you say that you expect there

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to be a reasonable relationship, though, you're not willing to put a number on it, are you, assuming that the AWP provides some indication of what the physician is paying to acquire drugs?
MR. COCO: Objection.
A. I'm saying -- AWP is -- is an industry indice that was used. So, it's the basis for comparison. It's a place that we should look to start.
Q. I agree -- I don't disagree with any of that. I think that's all self-evident. It doesn't really answer my question.
A. Uh-huh.
Q. My question is, when you use the term "reasonable," are you assuming that AWP -- are you assuming that AWP does bear -- does provide some indication of what the cost of a drug is to physicians?
MR. COCO: Objection.
A. I mean, that's some deal that I wouldn't know.
Q. Well, if you're not making that

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assumption, then what's your basis for thinking the differential would be reasonable?
MR. COCO: Objection.
A. Again, just like -- I mean, for services that a plan reimburses, if we start with a number, and we assume that there's a reasonable margin built into that, again, standard with our methodology, standard with -- with the industry, I would not expect there to be an unrealistic relationship between that number and a number that a physician is paying to get that, implicitly implying that when they bill the payer, that there is lots of money to be paid.
Q. Well, when you said you assumed there's a reasonable margin --
A. Uh-huh.
Q. -- as we discussed earlier, when you used the term "margin," you're referring to the difference between AWP and acquisition, right?
A. Yes.
MR. COCO: Objection.
Q. So, when you say, "reasonable margin,"

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you're saying you expected there to be a reasonable difference between the AWP and the acquisition, right?
MR. COCO: Objection.
A. If any.
Q. Okay. And so, when you say a reasonable -- and you don't know what the physician is paying to acquire drugs, right? You don't know what the specific number is?
A. That's right.
Q. Okay. But you do know what the AWP is, 'cause that's published.
MR. COCO: Objection.
Q. Right?
A. I don't particularly -- I don't personally, but yes.
Q. You understand that AWPs are published.
A. Yes. Correct.
Q. So, when you assume that -- there to be a reasonable margin, and the only information that you have is the AWP, aren't you axiomatically taking the position that AWP provides some

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indicator of the cost of the drug to physicians?
MR. COCO: Objection.
A. I don't -- I mean, that's a level of detail that I don't get involved in. If there were no other factors involved, but clearly the physician -- AWP is the -- is a price the physician is paying for a drug. The drug is supplied. The drug is billed to the insurer.
Q. You said AWP is a price a physician is paying?
A. AWP is an index. It's a price. It's out there. It -- I don't know if that's the price the physician is paying. I'm -- I don't know that. There is a -- there is -- clearly, there is an AWP price that is set by the industry as the wholesale price. There is then a price that the physician pays to get that drug, and there is then a price that the insurer, some third party, pays the physician for administering that drug. The numbers can't all be the same.
Q. Let me ask you this: Here's a report from 1992 which says, "AWP is not a reliable

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indicator of a drug to physicians -- of the cost of the drug to physicians." Do you see that on Exhibit Fox 002?
A. I see it. I saw it for the first time when you gave it to me.
Q. Okay. Now, if someone at BCBS of Massachusetts had seen this report when it was published in 1992, they would have understood, as you do reading it now, that AWP is not a reliable indicator of the cost of a drug to physicians, right?
MR. COCO: Objection. That is so far out of bounds as far as the question goes.
MR. MANGI: You can make an objection. Please don't speak.
Q. Go ahead.
A. I can't make -- I'm -- you're asking me to get into the mind of two different people, the person who wrote this, and someone at Blue Cross in 1992. I can do neither.
Q. If someone at BCBS had seen this statement in 1992, would it have changed the

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reimbursement rates that were offered throughout the 1990s?
MR. COCO: Objection.
A. Again, I would have no way to know that.
Q. Well, when it says, "AWP is not a reliable indicator of the cost of a drug," doesn't that mean that the margin will vary from drug to drug?
A. I don't know.
MR. COCO: Objection.
A. I don't know.
Q. You don't know?
A. No. I'm just reading the sentence here. I don't see anything in this sentence that says that it's a different margin in drugs. I just see that it says, "AWP is not a reliable indicator."
Q. Okay. When it says it's not a reliable indicator of the cost, and this goes back to when I was asking if you understood what was meant by that term, when it says AWP is not a reliable indicator of the cost of a drug, that means the relationship between the cost and the AWP will

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vary, right?
MR. COCO: Objection.
A. I --
Q. That's not how you understand the sentence?
A. It's not a level of detail that I get into in my job. So, I'm giving you what I've got, which is -- I mean, I don't read any of that into this, and so, I wouldn't -- I wouldn't know that to be the case.
Q. I'm not asking you about the level of detail you get into in your job. I'm asking you to read this --
A. Uh-huh.
Q. -- here and now and reconcile it with the testimony you've given in this case this morning. My question is, when it says, "AWP is not a reliable indicator of the cost of a drug to physicians," doesn't that mean that the relationship of AWP to cost will vary from drug to drug?
MR. COCO: Objection.

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A. No. Again, I don't know that to be the case. I -- I hear what you're saying, and I'm reading what's here, but I'm not -- I'm not reconciling those.
Q. Let me ask you to turn to Appendix 2 of the document, which is a page entitled "Redbook." If you flip from the back, you should come to it.
A. Okay.
Q. Now, you're familiar with Redbook, aren't you?
A. Not directly. I mean, I'm familiar with the term.
Q. Okay. You know Redbook is a pricing compendia that publishes pricing for drugs?
A. I am.
Q. Okay. You know Redbook publishes AWPs for drugs, among other things, right?
A. That's my understanding.
Q. Okay. Now, turn to the bottom paragraph of this page, please, and read along with me. "Since the Redbook does not represent its AWP as a measure of the physician's acquisition cost for

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drugs, we compared physicians' invoice cost to Redbook AWP." All right. So, you understand there what the -- what the methodology was that the authors of this report were adopting, right?
MR. COCO: Objection.
A. I don't know that I understand it. I'm reading what you're reading, but --
Q. Okay. Well, you understand that they compared physicians' invoice cost to the AWP, right?
MR. COCO: Objection.
A. That's what it says.
Q. Okay. Now, looking at the last full sentence now of that paragraph, "Considering that we also found that there is no single discount rate which can be applied to the AWP to provide a reasonably-consistent estimate of the physicians' acquisition cost, we do not feel that AWP provides a useful measure of the acquisition cost for a drug to physicians." Do you see that?
A. I see it.
Q. Now, isn't that statement inconsistent

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with the position that you've adopted today in terms of your expecting there to be a reasonable relationship?
MR. COCO: Objection.
A. No, because again, I've not ever read this. So, I would have nothing to change my opinion.
Q. That's not my question.
A. That's my answer.
Q. My question is -- my question is, isn't it inconsistent with what you said?
MR. COCO: Objection.
A. I don't know. I don't know that. I don't know. I'm reading this and I'm not -- I don't know what's consistent or inconsistent. I'm just telling you that that's my understanding. I'll let you determine if it's inconsistent or not.
Q. Well, do you read this sentence as being consistent with your position?
MR. COCO: Objection.
A. I'm just taking what it says here at its

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words. I read it. It's interesting. I've not seen it before. And I'm not going to say if it's consistent or inconsistent. That's my understanding of what I believe, and this is a document that was written in 1992. So, I don't -- I don't draw the parallel between the two.
Q. And you think there's no relationship between the position you've adopted today and what this document is addressing?
MR. COCO: Objection.
A. I don't work for OIG or The Department of Health and Human Services, so I can't -- I can't draw a parallel, I guess, is what I'm saying.
Q. Okay. Let me ask you this: When the author says, "We do not feel that AWP provides a useful measure of the acquisition cost for a drug to physicians," today, with the knowledge that you have as an individual who's worked in this area, do you think that's correct or incorrect?
MR. COCO: Objection.
A. I don't change what I believe.

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Q. Well, that's not my question. My question is, do you think that is a correct statement or an incorrect statement?
MR. COCO: Objection.
A. I don't even remember -- what are we talking about?
Q. This sentence here, "We do not feel that AWP provides a useful measure of the acquisition cost for a drug to physicians." Okay. Do you agree with that statement today, or do you disagree with that statement?
A. I --
MR. COCO: Objection.
A. I don't have an opinion, because I don't have to agree or disagree with what the OIG says. It's their position, and it's their opinion. I don't have knowledge to agree or disagree with that.
Q. Okay. So, you have no position as to whether or not AWP provides a useful measure of the acquisition cost of a drug to physicians.
MR. COCO: Objection.

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Q. Is that your testimony?
A. No. What you're asking me to do is to read this statement and draw that conclusion into what I'm saying.
Q. I'm not. I'm not. I'm asking you to either -- to tell me if you agree with this statement, disagree with this statement, or have no view as to whether the statement is correct or incorrect, and no basis for assessing whether it's correct or not.
MR. COCO: Objection.
A. Again, I would say that there has to be a reasonable relationship between acquisition cost and AWP, irrespective of what's here. I mean, that's -- so --
Q. Okay. So, that's your position as you've previously stated, and that remains your position, regardless of anything the OIG may have said in 1992.
MR. COCO: Objection.
A. Yeah, I would say that's accurate, because I'm -- again, I'm not going to -- there's

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been a lot that's happened since 1992 to current. I can't trend this statement to today. If you had asked me that question in 1992, based on what I believed, I could reconcile to the document. But I can't reconcile that statement to this document, absent no other written communication that you're putting in front of me that's more recent than 1992.
Q. Well, what if you had seen the statement in 1992? Would that have changed your views?
MR. COCO: Objection.
A. I -- I can't answer the question. I don't know what I would have thought in 1992. I probably wouldn't be sitting here if it was 1992.
Q. Okay. Let me show you another document.
MR. MANGI: Mark this as Exhibit Fox 003.
("Analysis of CMS Average Wholesale Price Reform" marked Exhibit Fox 003.)
Q. Have you ever seen this document before?
MR. NOTARGIACOMO: Do you have another copy?

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MR. MANGI: You know, I do, but I'm a little low on that. This is the same document we were looking at yesterday.
A. I don't know -- I don't know if I've ever seen this. Just give me a minute. I just want to --
Q. Sure. Take your time.
A. (Witness reviews document.) Okay. I have, okay.
Q. Okay.
A. Yeah, I have.
Q. Have you ever seen this document before?
A. I've seen pieces. I don't know if I've seen the entire document, but I have seen -- there's sections of this that I have seen, yes.
Q. Okay. Now, you mentioned earlier in the day that at one point Blue Cross Blue Shield of Massachusetts had considered changing to an AWP-based methodology. Does this document pertain to that analysis?
A. Consider changing to an AWP methodology?
Q. To an ASP-based methodology.

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A. That's not what you said.
Q. Okay. I misspoke.
A. Yes. This was what I was -- yeah, this is what I would have recollected.
Q. Okay. And this was in February -- at least this document was generated in February of 2004, right?
MR. COCO: Objection.
A. That's what it says.
Q. Now, were you involved in consideration of this issue, whether or not to shift to an ASP-based methodology?
MR. COCO: Objection.
A. Well, I was in meetings where it was discussed, but there was -- I wasn't part of a group. No, I don't believe I was.
Q. Are you aware that Michael Mulrey previously identified you as part of the core group that was responsible for dealing with this issue and making a decision about it?
MR. COCO: Objection.
A. Obviously, I'm not aware of that, but it

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may have been discussed at a meeting that I was at, but I don't --
Q. Okay. Are you familiar with the Provider Financial Strategy, that work group?
A. Oh, yes.
Q. Okay. What is the Provider Financial Strategy Work Group?
A. That is a work group that looks to -- essentially, looks to set the reimbursement policy based on that pool of money I described earlier, so --
Q. And you're part of that work group, right?
A. Yes, I am.
Q. Okay. Now, Mr. Mulrey testified that this issue was considered and the decisions on it were made by the Provider Financial Strategies Work Group. Is that your understanding as well?
A. That would have been the place where it was discussed, yes.
Q. Okay. So, you're one part of the group that considered this issue.

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A. Yes, yeah.
Q. Now, I'd like you to turn to the second page of that document. That lists "Reasons For Reform."
A. Uh-huh.
Q. The first one is, "Physicians benefit from the spread between AWP and acquisition cost, creating an overpayment for drugs and costs for Medicare." Do you see that?
A. I do.
Q. Okay. So, this is one of the reasons -- knowledge of this fact was one of the reasons why BCBS of Massachusetts was considering whether or not a change should be made, right?
MR. COCO: Objection.
A. Well, I -- I'm reading it, so, it's on that page.
Q. Yeah. Do you recall discussions of this issue?
A. Not -- I mean, again, my recollection, I mean, again, this is -- I go to a lot of meetings. I remember having the conversation on AWP versus

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ASP. I don't really remember a lot of the detail as to what we talked about.
Q. Okay.
A. So, I'm reading it, but you know, I don't -- I don't vividly remember having a dialog about that point is, I guess, what I'm saying.
Q. Okay. But looking at this document here, you can see that was one of the reasons for a change that was being contemplated.
MR. COCO: Objection.
A. I read that in the document.
Q. And similarly, the third bullet says, "In 2002, oncologists collected approximately $600 million in overpayments." That was another factor that was considered, right?
MR. COCO: Objection.
A. I see that in there.
Q. Okay. Now, what was the eventual decision as to whether or not BCBS should move from its AWP-based methodology to an ASP-based methodology?
MR. COCO: Objection.

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A. You know, we -- we haven't moved to it yet. And I don't really -- again, it's a -- it's not a huge part of what I do, so there's -- there's not a lot of this where I may have run -- well, no, I'm up to speed on where we are. We haven't implemented it. Why we haven't implemented it, I think, was for a host of reasons, some of them operational in just implementing it. You know, communicating it, you know, I don't know exactly why we decided not to do it.
Q. Are you aware that Mr. Mulrey testified that one of the reasons it was not implemented is because ASP was not the industry standard?
MR. COCO: Objection.
A. I'm not aware of his testimony, and I'm not aware of that.
Q. Does that refresh your recollection as to whether or not that was a reason?
A. Not particularly. I don't recall that.
Q. Now, when -- when BCBS of Massachusetts moved from 100 percent of AWP to 95 percent of AWP

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in the '90s, did that raise any particular operational concerns?
MR. COCO: Objection.
A. I'm -- I'm not in the operations area, but I'm not aware of.
Q. Well, you just referred to the possibility of operational concerns.
A. Uh-huh.
Q. So, when the previous change was made in methodology, my question is, did that raise any operational problems?
A. I don't know. As with any change, when you're changing fee schedules or reimbursement, there are operations to actually put those in place. So, I don't know.
Q. Let me ask you to turn to Page 6 of the document.
A. Uh-huh.
Q. Now, this reflects the changes in drug administration fees that CMS was going to make when moving from an AWP-based system to an ASP-based system, right?

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A. I mean, I read that -- I'm reading that.
Q. Yeah. Now, you'll see that some of the increases in administration fees -- for example, take the procedure code 90782, which is seven from the top --
A. Yeah.
Q. -- that was increased by 385 percent. Do you see that?
A. I see that, yeah.
Q. Okay. And take a look down at the bottom there, 96520, second from the bottom --
A. Uh-huh.
Q. -- that was increased by 392 percent. Do you see that one?
A. Yeah.
Q. What is your understanding as to why CMS was increasing administration fees when moving from an AWP to an ASP-based methodology?
MR. COCO: Objection.
A. I really don't know, to be honest with you.
Q. You have no understanding as to why that

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was done?
MR. COCO: Objection.
A. No. No, I don't, actually.
Q. At the footnote it says, "The estimate does not take into account the applicable BCBSMA conversion factor yet to be determined." What's the conversion factor that's being referred to there?
A. That is what I referred to earlier where our fee schedule has a -- the RBRVS methodology; we get the methodology, we then apply. Medicare has its conversion factor, we have our conversion factor, so fees are then -- there is a multiplier that is used in calculating the final payment.
Q. The next page, on Page 7 this reflects that, "If BCBS of MA were to follow CMS in changing both its drug and administration fees in line with CMS's, its total savings would be in excess of $6 million," right? Do you see that?
MR. COCO: Objection.
A. Is negative a savings? Or is that a -- I'm not in finance, as you can tell, so, sometimes

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I don't know if --
Q. Well, let's, -- let's take a look at it. Look at "Drug Supplies Total" first. Do you see that, the first row?
A. Yes.
Q. The current Blue Cross level is $38 million and change.
A. I see that.
Q. The Medicare reform level would be 28 million.
A. Uh-huh.
Q. So, if BCBS were to make the change, it would save over $10 million?
A. I see that.
Q. Right?
A. I see that.
Q. So, for administration fees, it would increase the amount it was paying, so it would pay about $4 million more per year. Do you see that?
A. I see that.
Q. And the third row is the difference between the two, the total savings to BCBS

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following CMS would be in excess of $6 million.
A. I see that.
MR. COCO: Objection.
Q. Do you recall that being discussed at the time?
A. I -- just at a high level, just under -- just the difference between the drug supply versus the drug administration, but I don't remember specific details per se.
Q. Okay. Have a look at the next page. Now, this reflects the impact of the change to different specialty types. Do you see that?
A. Uh-huh.
Q. For example, oncology would see a difference of 23 percent in their reimbursement. Do you see that?
A. I do.
Q. Okay. Why was this sort of analysis relevant to the Provider Financial Strategy Work Group's analysis?
A. Again, the group, this is just one piece of the reimbursement picture, so, we look at -- in

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that group, and, again, I'm there 'cause of my role in working with physicians -- we look at all of the factors that go into making a decision on what our methodology is going to be. So, I imagine this must have been at a point in time where we were, you know, evaluating fee schedules and looking at -- looking at that stuff, but I don't know specifically.
Q. My question is, why does it matter?
A. Well, that group looks at -- anything that affects reimbursement, that group could look at it, things that are going on in the industry --
Q. Well, this is a specific issue, isn't it? This is whether or not to move to ASP under consideration here.
A. Uh-huh.
Q. Why is the fact that oncologists would see a difference of minus 23 percent in their reimbursement amount relevant to consideration of whether or not to move to ASP?
A. Well, I think -- I mean, I didn't produce the report. I can't tell you what.

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Q. But you were part of the group analyzing the report, right?
A. No, I was part of a group that was looking at the issue. I think that any time we make a change in policy, as I said to you earlier, I mean, we want to know who could potentially be impacted by any change of policy that we're making. So, it would be -- that's probably why we're looking at this is to see who would -- who would be impacted by any change that was being considered.
Q. And is -- is who would be impacted by a change considered one of the factors that was considered by the Provider Financial Strategies Work Group in deciding whether or not to move to ASP?
A. You know, I don't -- I don't recall that conversation. I think -- it could be one factor, in addition to numerous other factors. But it would be -- it would be something that we would consider.
Q. Okay. Let me ask you to turn to Page 12

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of the document. Option 1 there is, "Move to CMS ASP with change in admin fees." Do you see that?
A. Uh-huh.
Q. Why was Blue Cross Blue Shield of Massachusetts contemplating changing its admin fees while moving to CMS ASP admin fees?
A. I don't know. That's a little outside the realm of my world.
Q. Well, if it had been decided that this was the option that BCBS wanted to adopt, how long would it have taken to implement that?
MR. COCO: Objection.
A. Again, I -- I have no idea what the detail is behind this page. I couldn't answer that. It depends -- depends on what the changes are.
Q. Okay. Who would know the answer to that question?
A. Mike Mulrey, person you mentioned, I think, is probably one, and -- yeah, Mike. I mean, Mike administers the fee schedule, so Mike would know how long it would take.

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Q. Would Deb Devaux know the answer to that question?
A. I have no reason to -- if I don't know the answer. I don't know that Deb would know the answer. I think Mike is the best person for that, because Deb Devaux is not managing the fee schedule.
Q. Now, the cons listed here are "High impact to certain provider types, i.e., oncology." That's listed as a con. Now, from your perspective in provider relations, is that a factor that you considered relevant to this analysis?
MR. COCO: Objection.
A. Any time we're making a change that affects provider types, it's relevant for me, because it affects what I do, sure. May not be relevant for a lot of other people, but for me it is.
Q. So, the fact that there would be a significant impact on oncologists was one of the factors that was a con associated with a shift to

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ASP, right?
A. I see that. But again, I think --
Q. That -- go ahead.
A. I think we would have taken -- I think then this conversation is in isolation. We then would have to look at the rest of our -- we're talking about a real narrow piece of their reimbursement. We'd have to look at what the impact is across the board for all of their reimbursement, but reading this con, yes.
Q. Another con listed as, "Potential shift to facility setting (oncologists.)"
A. Uh-huh.
Q. What is that referring to?
A. My understanding would be that -- if I -- if I recall this -- that if the oncologists didn't agree or, you know, weren't -- weren't satisfied with this level of reimbursement, that they could potentially not provide the service in their office and send patients to the hospital.
Q. Why is that a con?
MR. COCO: Objection.

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A. Well, I don't think it's real convenient for patients to have to go to the hospital.
Q. So, patients would prefer to be treated in a physician's office rather than a hospital?
A. Wouldn't you?
Q. I certainly would. I'm asking if you would agree with that.
A. I would agree.
Q. Okay. Any other reasons why that's a con?
MR. COCO: Objection.
A. No, I mean, no, I mean, I think that's -- that's the primary reason.
Q. Would there be a different cost to Blue Cross Blue Shield of Massachusetts in terms of the amounts it reimburses if these drugs were delivered in a hospital outpatient department versus a physician's office?
A. Sure.
Q. Which is higher?
A. Hospital. I'd say the hospital reimbursement would definitely be higher.

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Q. So, if oncologists were to stop treating patients in their offices -- withdraw that. If oncologists were to stop administering drugs to patients in their offices and were to instead send them to a hospital outpatient department --
A. Uh-huh.
Q. -- that would end up costing BCBS of Massachusetts more, is that correct?
A. It could.
Q. Well, would it?
A. Again, I mean, I -- without having hospital contracts in front of me and looking at reimbursement rates, I mean, in a hypothetical situation, hypothetically, it could.
Q. I'm not asking --
A. Yeah.
Q. -- about, you know, specific contracts.
A. Yeah.
Q. I'm asking as a general matter based on your understanding of the difference.
A. Yes. Yes. In general, it would. And that would be -- again, I think that would be

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another factor we'd look at.
Q. Another reason -- another -- withdraw that. Take a look at Option 2, which is, "To move to the ASP basis without a change in the service fees." Do you see that?
A. Uh-huh. I do.
Q. Okay. Now, here the subbullet says, "The option would include adopting the CMS ASP drug fee methodology while applying a multiplier to the fees. This option would allow BCBSMA to adopt the CMS ASP methodology without reducing the total payments for drugs on a networkwide basis." Do you recall this being an option that was discussed at the time?
A. Again, at a high level, I know there they were options. I don't remember. There's lots of things we talked about at that meeting. I don't remember the specific conversation.
Q. Well, by "budget neutral," what was being contemplated here was shifting to ASP, but then applying a multiplier so the total reimbursement would not change, is that accurate?

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A. That looks to be right.
Q. The third option is to "Maintain the current 95 percent of 2004 ASPs."
A. Uh-huh.
Q. But again, the problem noted there as a con would be that those drug fees would be stagnant because CMS would no longer be using the AWPs, right?
MR. COCO: Objection.
A. I just see "Stagnant drug fees." I don't know what that means, but --
Q. Okay. Well, compare Option 3 to Option 4. Option 4 is, "Find drug vendors who can supply AWPs on a J-Code level." And the pro is, "Can maintain current 95 percent of AWP methodology level." What was the difference between Options 3 and Options 4?
A. Now, you're outside of my realm. I -- you'd have to ask -- well, you'd have to ask the folks that produced the report what they meant by the options. Again, I participate in the conversations. There's lots of things that we

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discuss where I don't have a detailed knowledge, because I really don't need it. So, I don't really know what the differences are between those options. I'm reading the same thing you are.
Q. Do you recall any options that were considered by the Provider Financial Strategies Work Group other than the four options that we have discussed here?
A. Not particularly, no. I don't.
Q. So, the provider financial strategies never contemplated -- well, withdraw that. Did the Provider Financial Strategies Work Group ever contemplate simply following CMS -- well, I should withdraw that. At the next page of this document, under "Next Steps --"
A. Uh-huh.
Q. "Does BC 65 have to follow CMS's drug payment methodology?" What is BC 65?
A. Blue Care 65, which would have been a Medicare Advantage plan, Medicare Plus Choice at the time.
Q. Okay. What is a Medicare Advantage

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plan?
A. Medicare Advantage is an HMO contract that the plan enters into with CMS to provide over 65 beneficiaries with direct and group coverage for services.
Q. Did BC 65 reimbursements follow CMS's payment methodology?
A. Blue Care 65, because it's funded -- essentially, we use the Medicare fee schedule for most of the -- for most reimbursement. Yeah, we do.
Q. So, did Blue Care 65's reimbursement methodology move from 95 to 85 percent of AWP when CMS moved?
A. I don't know. I don't know that.
Q. Did Blue Care 65's reimbursement methodology move to an ASP-based methodology when Medicare moved?
A. No. No, I don't think it did.
Q. So, Blue Care 65 continues to reimburse at an AWP level?
A. I can't answer that for certain, because

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again, I'm not in that -- I'm not operations area. But that would be -- there are other examples than Blue Care 65 where we, for operational reasons, we can't follow the Medicare pricing model, so we've had to create our methodologies.

We're not mandated to follow Medicare policy, but based on the way the product is funded, it's easier to follow Medicare. But we don't -- it's not a hundred percent across the board. There are lots of other examples where we're not doing that.

Q. So, it would be easier to follow Medicare but Blue Care 65 is not --

A. No, I don't think I said that.

MR. COCO: Objection.

A. I said it the way the product is funded, it's funded from CMS at a fixed cost to the plan. If the Plan wants to essentially take that reimbursement and have that product just pass that cost directly through, it can follow the Medicare guidelines and policies. It doesn't have to. It's not a requirement. In instances where it

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makes sense, we do. In others where it's operationally difficult, we don't.

Q. Let me ask you a couple of quick things, and then we'll take lunch.

A. Sure.

Q. Does -- do you, in your current role, ever review or analyze contracts between BCBS of Massachusetts and physician practices?

A. Well, I guess "analyze," what do you mean by "analyze"? I mean, am I involved in contracts with physicians?

Q. Do you -- are you involved in the drafting of those contracts?

A. I am. I can be.

Q. Are you familiar with the terms of those contracts?

A. Not everything, but some of them, sure. The ones I'm involved in, I am.

Q. At some point in the last few years BCBS of Massachusetts implemented a specialty pharmacy program. Are you aware of that?

A. I'm not aware of the details. I'm not -

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- I don't have responsibility for specialty pharmacy, but --

Q. Are you aware that that was done?

A. Yeah.

Q. Do you -- did you play any role in that process or provide any input to the determination to what the parameters of what the specialty pharmacy program would be?

A. Not that I can recall, no.

Q. Did -- were you involved in any meetings where the specialty pharmacy program was discussed?

A. I can't recall that I have been, no.

MR. MANGI: Okay. This is a good time to take lunch.

(Whereupon the deposition recessed at 1:21 p.m.)

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AFTERNOON SESSION (2:06 p.m.)

(Attorneys Notargiacomo and Skwara not present.)

Q. Now, Mr. Fox, before the break we were looking at Exhibit Fox 003, and there were four different options listed there. Do you recall that?

A. I do.

Q. Which of those options, if any, was implemented?

A. Give me a minute. (Witness reviews document. I don't know that we actually -- I don't know that we actually made a decision on this. If we did, it's Option 3, because we're still at 95 percent of AWP. So, I would say that that's -- since that's one of the options that listed there, we either didn't do anything or we picked that as the option.

Q. Well, 95 percent of AWP is also Option 4, isn't it?

A. I don't believe we did that.

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Q. Okay. Are you familiar with R J health?
A. With who?
Q. RJ Health?
A. No, I'm not.
Q. Previous BCBS of Massachusetts witnesses have testified that RJ Health is a vendor that BCBS of Massachusetts has hired to supply AWPs on a J-code level. Do you have any reason to think that's incorrect?
A. No.
Q. Okay.
A. It's not my -- it's not my world, so --
Q. Okay. Well, you are a part of the work group that made the decision on what to implement, right?
A. Correct.
Q. Okay. So, it's part of your world to that extent. Now, taking a look at Option 3 and 4, as part of the Provider Financial Strategy Work Group, do you understand these to be the same thing or is there a difference between them?
A. (Witness reviews document.) By

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definition, they're not the same. I don't -- I don't know the details behind what is, you know, obviously, given that I'm not even aware that we have a vendor doing it, so, I -- you know, they look to be different. I couldn't tell you what the specific differences are. That would not have been discussed at a meeting I was at.
Q. Now, would you turn back a moment to Exhibit Fox 001?
A. Which was the subpoena.
Q. Turn back to Topic No. 2, please. It's on Page 12 of the document. Let me know when you're there.
A. Yeah.
Q. Okay. Now, you see that one of the parts of that deposition topic is the use of specialty pharmacies?
A. Correct.
Q. Okay. So, you've been designated as a knowledgeable witness to speak about Blue Cross Blue Shield of Massachusetts' use of specialty pharmacies, right?

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A. To the extent that we use them, so, I would say yes.
Q. Well, before the break I understood from your testimony that you were not knowledgeable about what was considered and whether to use specialty pharmacies, what the parameters of the program would be.
A. Sure.
Q. Did I understand that correctly?
A. I'm not -- I do not do the contracting for specialty pharmacies. Certainly, from a reimbursement perspective, I certainly understand what reimbursement methodologies are. Again, to the extent that we're working with physicians here, but I'm not -- I don't work directly with specialty pharmacies.
Q. And you have no understanding as to why physician-administered drugs were excluded from the scope of the specialty pharmacy programs that Blue Cross Blue Shield of Massachusetts implemented.
A. No, I do not.

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Q. Did you see any of the documents that were generated as part of the process of considering those issues?
A. Which process are we talking about?
Q. Did you see -- let me rephrase the question. Have you seen or did you see any of the documents that were generated at Blue Cross Blue Shield of Massachusetts in connection with efforts to determine the appropriate scope for the specialty pharmacy program, specifically whether or not it should include physician-administered drugs?
A. I don't believe so.
Q. Okay. Now, I'd like to turn to a different topic, which is the clients of Blue Cross Blue Shield of Massachusetts. Who are the health plan's clients?
MR. COCO: Objection.
A. What do you mean by "clients"?
Q. Well, do you have an understanding of the meaning of the term "client"?
A. Well, client could mean an account, a

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broker, customer.
Q. Okay. Who do you understand to be Blue Cross Blue Shield of Massachusetts' customers?
A. Accounts --
MR. COCO: Objection.
A. -- brokers.
Q. Okay. What sort of entities are you thinking of when you say, "accounts"?
A. I'm not thinking of any particular account.
Q. Okay.
A. I'm just thinking of accounts in general.
Q. Let me rephrase the question. Are employers -- companies that employ individuals -- clients of Blue Cross Blue Shield of Massachusetts?
A. I would agree with that definition.
Q. Similarly, then do the clients of Blue Cross Blue Shield of Massachusetts include health and welfare funds?
A. They should.

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Q. Unions?
A. Anyone who's contracted with us for services could include any of those.
Q. Now, when -- let's take -- let's take a specific example. Are you familiar with the Pipe Fitters Local 537 Trust Fund?
A. Not specifically.
Q. Okay. But you're aware that that's one of the trust funds -- one of the types of entities we're talking about? Are you familiar with the entity?
A. (Witness nods.)
MR. COCO: Objection.
Q. Never heard of it?
A. No.
Q. Okay. Well, let's talk about any generic health and welfare fund then. Let's call it Customer X. When Customer X, a health and welfare fund, comes to Blue Cross Blue Shield of Massachusetts seeking to obtain coverage for its members, does it enter into a contract with Blue Cross Blue Shield of Massachusetts?

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A. I'm not -- I'm not on the sales side of the house, but that's -- my understanding is that they do.
Q. Do the clients of Blue Cross Blue Shield of Massachusetts, by contracting with Blue Cross Blue Shield of Massachusetts, then get access to Blue Cross Blue Shield of Massachusetts' provider networks?
A. Yes.
Q. Do any of Blue Cross Blue Shield of Massachusetts' clients have their own networks?
A. I'm not aware that this exists.
Q. So, as far as you know, all of them use networks provided by Blue Cross Blue Shield of Massachusetts?
A. As far as I'm aware, yes.
Q. The terms -- because they're using Blue Cross Blue Shield of Massachusetts' network, the terms of reimbursement are then determined by what's been agreed between Blue Cross Blue Shield of Massachusetts and the provider, right?
MR. COCO: Objection.

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A. Repeat this -- just repeat the question.
Q. Sure. Well, when a client comes to Blue Cross Blue Shield of Massachusetts -- a health and welfare fund, for example -- they enter into a contract with Blue Cross Blue Shield of Massachusetts that gets them access to Blue Cross Blue Shield of Massachusetts' provider network, right?
A. That's correct.
Q. Now, Blue Cross Blue Shield's contract with the providers, the contract that sets out the network, that provides for what the payment terms to the provider will be, right?
MR. COCO: Objection.
A. Our contract with our provider sets the payment terms.
Q. So, Blue Cross Blue Shield of Massachusetts' clients are not directly involved in negotiating the amount that will be paid to the provider in reimbursement, is that correct?
MR. COCO: Objection.
A. They -- they may not be directly, but

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they -- we are -- in our role, we are actually -- the whole point of entering into those negotiations and the whole point of those reimbursements is essentially to pass on any of those savings to our accounts.
Q. You're acting on behalf of your clients in contracting with the providers.
MR. COCO: Objection.
A. That's correct.
Q. Are you familiar with the Teamsters?
A. I know who they are.
Q. All right.
A. I know they're an account.
Q. Are you aware that Teamsters Local Health and Welfare Fund are clients of Blue Cross Blue Shield of Massachusetts?
A. Yes, I am.
Q. The facts that we just discussed in terms of the networks of relationships, those apply, I believe, to the Teamsters, that's one example of the type of customer that would have these relationships?

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MR. COCO: Objection.
A. I can't speak to the Teamsters' contract with us, I -- again, at a high level, our networks are available to our accounts.
Q. I use Teamsters as an example of one of the types of funds we've been talking about.
MR. COCO: Objection.
Q. Now, other than Blue Cross Blue Shield of Massachusetts, are there any other entities that have their own provider networks in Massachusetts?
A. Are there other entities? Other health plans?
Q. More broadly, any other entities you're aware of that have their own networks of providers.
A. Well, I mean, "network" is a pretty broad term. Pharmacies have a network of pharmacies, chains --
Q. I'm talking about networks of providers, of physicians.
A. I don't -- I mean, I just don't think I

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understand what your question is.
Q. Blue Cross Blue Shield of Massachusetts has contracts with providers -- has set up a provider network, right?
A. That's correct.
Q. Okay. Other health plans, the CIGNAs, the Fallons, the Neighborhoods, they similarly have their own networks of physicians, right?
A. They have -- they have their own networks. They're largely the same.
Q. Now, other than these entities, the health plans that we've talked about, do you know of any other entities in the marketplace that have networks of contracted physicians in Massachusetts?
A. There may be disease management vendors, but I'm not -- I mean, I'm not aware specifically. I'm not sure what you're thinking of, but I can't think of anything.
Q. Are you aware of any employer plans in Massachusetts, including unions' health and welfare funds, that maintain their own provider

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networks?
A. I'm not aware of any that maintain their own.
Q. Are you aware of any employer plans -- including health and welfare funds -- that negotiate reimbursement rates with physicians directly?
A. I'm not aware of that.
Q. Now, earlier in the day we were running through your employment history at the company, and we got up to the period '95/'96 when you were a network manager. Do you recall the --
A. Yeah.
Q. -- we were talking about that?
A. Yes.
Q. What was your next position after network manager?
A. Would be regional director.
Q. When did you move into that position?
A. It was probably -- probably right after that, '97.
Q. How long did you stay in that position?

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A. I would say '97 to 2000.
Q. What were your responsibilities as a regional director?
A. Just -- I mean --
Q. I'm sorry. Withdraw that for a second. Was that a regional director in a particular department?
A. Regional director of provider relations.
Q. Okay. Now, what were your responsibilities in that position?
A. The responsibilities were to coordinate the activities of staff and essentially -- it becomes largely an internally-based role, versus in the previous roles, which are more externally-based. You get more involved in management and administration and representing kind of a particular region, and just -- instead of having a knowledge or relationship of a particular group of providers, you become knowledgeable around a larger group, more at a regional level.
Q. Were you still dealing directly with provider groups?

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A. Sure. I maintained some relations out there, but -- yeah.
Q. Was that a smaller proportion of your time than it had been previously?
A. Yes. Yes. Definitely.
Q. What proportion of your time was spent in direct contact?
A. Probably less than 25 percent.
Q. Now, after the regional director stint from '97 through 2000, what was your next position?
A. Director.
Q. Director of provider relations?
A. Director of provider relations, and then I took on communications as well.
Q. How long was your title just director of provider relations?
A. It wasn't. It was when I took on the director of provider relations, with that came the other department, which was a separate department.
Q. And remind me, what was the full title?
A. At that time it was provider relations

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and communications.
Q. Okay. So, how long was your title, director of provider relations and communications?
A. Till a year ago, February of 2005.
Q. And what did it change to in February of '05?
A. Senior director of provider relations, communications, and eHealth.
Q. Now, is provider relations and communications the same thing, or is it two separate tasks in that title?
A. It's two different departments.
Q. Okay. What's the function of provider relations, and what's the function of provider communications?
A. Provider relations is responsible for the external administrative relationships. I think I may have mentioned -- I mentioned in my other -- earlier we talked about the role. It's working with physicians, doing a lot of education, training, you know, helping them to understand how to work with the plan. It also is involved in

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implementing contracts that were executed under -- you know, so physicians knew what the terms were, etcetera.
The communications side of -- is communications strategy. All of the external provider communications that the Plan produces come out of this shop, all the newsletters, organization of meetings, things like that.
Q. In the communications role, does that focus on communications from BCBS to physicians, as opposed to the communications?
A. Correct.
Q. Okay. So, the focus is on mailings and things like that which are being sent out to physicians?
A. That's correct.
Q. Insofar as this communication going the other way from the physician to BCBS of Massachusetts, that would be part of the provider relations department rather than provider communications department?
A. That's accurate.

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Q. Okay. Now, if Feb of '05, title changed from director to senior director. Was that just a promotion?
A. It was more at a responsibility level. I took on an additional area of eHealth, so by getting the department and really, just more of an external -- because now I'm spending a lot more time externally than before. So, it's just a -- it's a distinction the company is making, because you have director levels, and there are senior director levels. So, they've made the distinction.
Q. And what is the eHealth component that was added to your responsibilities?
A. It's working with physicians -- well, it's actually working with providers on adopting and implementing electronic technology. So, it could be electronic medical records and things like that.
Q. Okay. Does that include claims processing-related issues?
A. No, not typically.

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Q. Is it a focus on record keeping?
MR. COCO: Objection.
A. No.
Q. Okay. So, what other than medical records is part of that -- the focus?
A. It's really around changing the physician -- essentially, getting physicians to adopt technology to make their office more efficient, but not on a billing side. So, it would be things like getting them to adopt medical records, getting them to use handheld for electronic prescribing; it will get them to take a look at clinical decision-making, things like that.
So, it's really that component. And since that group is responsible for working with physicians, it made sense to pull them into my area.
Q. And that senior director is still your title today, right?
A. At least it was when I left.
Q. Now, who do you currently report to?

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A. I report to -- I report directly to Vincent Plourde.
Q. And Mr. Plourde is a VP director?
A. That's correct.
Q. What is the VP for?
A. He is responsible for provider services. Most of his -- I've got responsibility for my whole area. When I took the role in 2000 -- I think it was with him since 2001, 2002, probably in that time frame. He has -- his responsibility is the claims processing area, really just -- the call center, if you will -- when people have problems with their claims, they call in. And so, he had responsibility for that entire side of the house.
And so, they put us together, but I certainly have a lot more detailed -- he doesn't work with physicians in the field. I do, so --
Q. So, what are his responsibilities? What areas does he deal with?
A. He has -- well, again, he's internally-based, largely. And he is responsible for

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representing the -- really, the provider operations side of the house up into senior management.
Q. Okay. Well, one of the areas he has oversight over is provider relations and communications, right?
A. That's correct.
Q. What are the other areas he has oversight over?
A. Provider services, as I mentioned, is the other area. I think it -- provider support, which includes a lot of -- more of a system, understanding how -- how our system is configured. But not IT, more from a claim perspective. And he also has the provider audit area. So, he's responsible for hospital audit.
Q. How long has he been in his current position, do you know?
A. He was elevated to vice president when -- probably in 2001.
Q. And you've reported to him since that time?